# Department of Mental Health (DMH)
# Mental Health Services Act (MHSA)
# INTEGRATED PLAN ADVISORY WORKGROUP
## June 30, 2008

# Summary
## For Discussion Only

## I. Background

The Mental Health Services Act (MHSA) became state law on January 1, 2005. The passage of the Act created the expectation of a comprehensive planning process within the public mental health system. The multiple components of the MHSA were designed to support one another in leading to a transformed, culturally competent mental health system. This is reflected in the California Department of Mental Health's (DMH) *Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act* of February 16, 2005: "As a designated partner in this critical and historic undertaking, the California Department of Mental Health will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families. In its implementation responsibilities under the MHSA, DMH pledges to look beyond "business as usual" to help build a system where access will be easier, services are more effective, out-of-home and institutional care are reduced and stigma toward those with severe mental illness or serious emotional disturbance no longer exists."



The meeting summarized here, held on June 30, 2008 in Sacramento, was the first advisory workgroup meeting focused on DMH-developed Integrated Plans. Forty-one (41) people were in attendance. This summary reflects the content, questions and comments from the meeting.

## II. Welcome, Introduction and Overview of the Process

Beverly Abbott, consultant to DMH, welcomed participants to the Integrated Plans Advisory Workgroup meeting. First, she reviewed the goals for the meeting, which were:

1. To present and obtain feedback about proposed phased steps and timelines for the Integrated Plan; and
2. To present and obtain feedback regarding the concept of the Integrated Plan Quality Improvement planning process.

The meeting was designed to offer the opportunity for a discussion about the Integrated Plans within the context of a quality improvement process. DMH and county mental health services departments have expressed commitment to using this quality improvement framework to improve services.

Carol Hood, DMH Assistant Deputy Director for Community Program Development, provided a brief update on DMH progress and a history of the MHSA stakeholder process. Since MHSA became state law, DMH has introduced each of its components through a series of stakeholder meetings. At this point in time, DMH has adopted guidelines for all components within its purview. The MHSA Oversight and Accountability Commission (OAC), which has responsibility for Prevention and Early Intervention (PEI), has provided the principles and DMH issued the final set guidelines for the PEI component and counties are beginning to submit their plans.

Ms. Hood described a study of the statewide stakeholder process, which showed that while the process was large and welcoming, it lacked representation from underserved communities. For each component's implementation, DMH has developed a specific stakeholder process. For the stakeholder process for the Integrated Plans, each person on the advisory workgroup was invited because s/he is connected to a broader constituency, with the expectation that participants will bring those voices to the discussion. Therefore, after each meeting, there will be a week in which participants are invited to provide additional feedback from their community groups for DMH to use in planning for the next step.

Each participant introduced himself or herself. Participants included representatives from a variety of stakeholder constituencies: family members and consumers from DMH's expert pool, State departments, community-based organizations, service providers, state contractors, county mental health directors, grassroots and professional advocacy organizations and organizations representing cultural groups.

Ms. Abbott and Ms. Hood then reviewed the agenda and the process for the Integrated Plan stakeholder process. This first meeting is designed to present information to provide the context for the Integrated Plan, introduce initial thinking about performance indicators, facilitate input through small facilitated group discussions, small group report outs and a summary of key issues and anticipated next steps. This process is anticipated to include two more meetings: July 30, 2008 and a meeting in late August. DMH requests consistent participation over the three meetings. All documents related to upcoming meetings will be posted no later than one week before each meeting.

## III. Overview of Integrated Plan

Ms. Hood provided an overview of the Annual Updates and Three Year Plan, using a PowerPoint presentation available on the MHSA website (http://www.dmh.ca.gov/Prop_63/MHSA/default.asp), beginning with review of relevant parts of the MHSA statute pertaining to the integrated plan and DMH's responsibilities.

***MHSA Vision***

- An approach to services and supports through which clients and their families, when appropriate, participate in the development of individualized services and supports plans.
- County mental health programs enter into partnerships with clients, their families and their communities to provide, under client and family direction, whatever it takes to enable people to attain their goals.
- Beyond "business as usual" to build a system where
    - access will be easier and earlier
    - services will be more effective
    - out-of-home placements, institutional care, homelessness and incarcerations will be reduced
    - stigma toward those who are diagnosed with serious mental illness or serious emotional disturbance will no longer exist.

***Fundamental Concepts/General Standards****

1) Community Collaboration
2) Cultural Competence
3) Client/Family driven mental health system
4) Wellness focus, which includes the concepts of recovery and resilience
5) Integrated services experiences for clients and their families
6) Commitment to prevention and earlier intervention.

* The first five fundamental concepts/general standards are included in the MHSA regulations as General Standards.



***Implementation Phase***

- After MHSA was passed, there was an initial stakeholder input process, involving many meetings in northern and southern California. DMH attempted to include underserved communities but did not succeed. As a result, DMH is now working with cultural brokers who are having more success in reaching these underserved communities. Stakeholder input was sought
    - At the state level, to help set the vision and guidance regarding implementation.
    - At the local level, to help establish local needs, priorities and strategies.
- With stakeholder input, DMH developed principles, guidelines and regulations, and is responsible for approval of local plans.
- With stakeholder input, counties are responsible for plan development and initial program implementation.
- DMH and counties are still in the early stages of lifting MHSA off the ground.

***Progress on Implementation***

- Community Services and Supports (CSS):
    - All counties have approved plans.
    - The expected funding level for Fiscal Year 2008/09 is $650 million.

    - MHSA Housing Program:
        - DMH, the California Housing Finance Agency (CalHFA) and the County Mental Health Directors Association created the program to finance the capital costs and operating subsidies for creation of permanent supportive housing for individuals with mental illness and their families.
        - The program embodies both the individual and system transformational goals of MHSA through a unique collaboration among government agencies at the local and state level.
        - There have already been seven applications, two of which have already been approved.
- Prevention and Early Intervention (PEI):
    - The OAC completed principles and guidelines for local plans.
    - Plan submission has begun, with the first three PEI plans submitted.
- The strategic plan on suicide prevention has been drafted. (Note: it was approved by the Governor on 6/30.)
- The following State Administered Projects are proceeding:
    - Student Mental Health Initiative
    - Stigma and Discrimination Reduction
    - Suicide prevention.
    - Reduction of disparities for underserved communities
- Workforce Education and Training:
    - The Five Year Strategic Plan was completed and approved by the Mental Health Planning Council.
    - As a result of the planning process, California increased by 25 the areas with workforce shortage designations, which broadens opportunities to access federal funds.
    - County plans have been submitted by ten counties, of which seven have been approved.
- Capital Facilities and Technological Needs:
    - One component plan has been submitted for the initial and overall design.
- Innovation:
    - OAC has provided principles; guidelines are under development by DMH.
- Overall:
    - DMH is nearing completion of guidelines for all components.
    - There is still a long way to go, even with all the work invested by many people.
    - DMH revised fiscal policies and procedures. It took about a year to re-examine all DMH fiscal policies, taking a broad perspective that included a look at local funding. It was a substantial shift in terms of perspective regarding who is in charge of the funding. This shift necessitated not only a new attitude, but subsequent review of all policies using that new attitude.
    - DMH refined CSS plan update submission policies and its own role in continuing approved programs. It was reported that, at some point during the day, June 30, 2008, a policy letter was expected to be signed by Dr. Mayberg, DMH Director, that would address streamlined county reporting requirements,

- DMH is currently focusing on evaluation design, using a long term rather than a short term perspective about evaluation of MHSA progress and outcomes.

**Current Context**

- Overall, there is a strong, continued commitment to the vision of transformation for the entire public mental health system, not just for MHSA funded programs.
- Counties have been working hard to design and implement services and supports. At the ground level, there is still significant overwhelm. The action for MHSA is truly visible on the local level, where the changes are happening.
- Counties have found the MHSA implementation process to be very challenging, and the process has been too long and bureaucratic.
    - Counties and their stakeholders have been inundated with planning and implementation of MHSA's multiple components. The separate roll required many separate processes to take place simultaneously, adding stress to the system.
    - The inconsistencies between different components' requirements and processes have been frustrating for counties.
    - Plan documents have proven not to be usable or useful for local communities. While the counties have had robust stakeholder planning processes, they have found that the forms to be submitted to DMH do not allow for adequate description of the processes.
- The process has been too long and bureaucratic.
    - The focus has been on implementing services and supports, trying to move programs forward so that services can be provided.
- Initial accountability has been designed to be consistent with the implementation phase. DMH does not hold counties accountable for every detail in their plans. Changes in the numbers of clients or in the budget do not require budget amendments, as one example of transformation and reduction in bureaucracy. Accountability is targeted to implementation, whether counties are implementing the programs described in their plans.
- The funding for the public community mental health system and its base programs is insufficient.
    - The system is in significant stress with significant change: implementation of MHSA combined with significant reductions in core services has resulted in significant stress, what has been described as building a new roof on crumbling foundations.
- More clarity regarding governance roles and responsibility for the MHSA has been established.
    - DMH and OAC have done a great deal of work and much still needs to be done in clarifying their interdependent and independent structures and responsibilities. The structure is challenging, but everyone is committed to successful collaboration. DMH and OAC are developing a Memorandum of Understanding (MOU) to delineate their different roles and responsibilities.

- There is a significant change in the understanding of the respective roles of state and local mental health departments with regards to MHSA roles and responsibilities.
    - DMH has established a framework for implementation and provides assistance, oversight and evaluation.
    - County mental health departments determine community priorities and strategies, implement programs and manage funds.
    - There has been a reaffirmation of the local role in designing programs. Initially, it was thought that program design should be driven by DMH. The concept has changed to shift responsibility to the counties, within a framework provided by DMH to assure accountability.
- MHSA expects integration. Originally, this was thought to mean only the integration of the components within MHSA, but it has since come to mean the integration of MHSA with the entire public mental health system now.
    - MHSA services are separate from the overall public mental health system. In the long run, this will not be healthy for provision of services.

***Integration Phase***

- As we continue to pursue the overall goal of transformation, we are also in a new developmental phase. Priorities are to
    - Simplify and streamline processes consistent with a new understanding of roles.
    - Move toward indicators with a focus on quality improvement processes.
    - Integrate: first, components of MHSA with each other and then, MHSA into larger system. There will still be separate components according to the MHSA statute, but these can be brought together into a more cohesive document and plan. Eventually the goal is to integrate MHSA into the larger mental health system. DMH does not have a lot to do with much of the larger system; Realignment governs those areas. It will be a challenge to deal with the different authorities. There seems to be a general consensus on the goal of integration of MHSA in the broader system.
- DMH is committed to a new way of doing business and to transformation.
- Part of MHSA's developmental process is the move from implementation to integration.
- As MHSA proceeds, there will be increasing clarity regarding the roles of DMH and local communities which will affirm the local role in determining priorities and strategies. Processes and accountability should be consistent with those roles.
- Local stakeholders must be provided with the information, abilities and opportunities necessary for them to determine what is and is not working in their communities, to have a significant impact on program design, and to be empowered to hold their public mental health system accountable for progress toward the priorities and services they care about and need.
- DMH will shift from placing a significant focus on plan descriptions to looking at indicators of whether counties are making progress on their selected goals and objectives.
- DMH will require that counties monitor an as yet unspecified set of major indicators.

- Counties, in conjunction with local stakeholders, will be able to select additional indicators of most importance to them.
- The integrated planning process will look at these indicators as part of the process of assessing the functioning and needs for change in local county mental health systems.

***Plan for Integrating the MHSA into the Public Mental Health System***

- By 2008-09: DMH will simplify requirements and performance indicators for all MHSA components, resulting in a streamlined county requirement for submitting a single MHSA Annual Update.
    - Each county's MHSA Annual Update will describe its previous year's MHSA activities and request funding for next year's MHSA activities.
- By 2009-10: DMH will development requirements for a new three year plan that will reflect how MHSA resources are one tool to meet local needs that resides within the larger public mental health system.
- By 2011-12: The first one-third (1/3) of counties will determine local needs, goals, priorities and will write three year plans that integrate MHSA with the overall public mental health system. An integrated three year plan will describe how the counties will use MHSA to fill those needs.
- By 2012-13: The second 1/3 of counties will complete their plans.
- By 2013-14: The last 1/3 of counties will complete their plans. By this time, there will be plans in all counties for a fully integrated public mental health system.

***Annual Updates General Proposed Content***

1) Assurance of compliance with requirements. There are currently assurances for each component. DMH proposes folding these into one assurance.
2) Report on prior year activities, which will replace the CSS Implementation Progress Report.
3) Funding requests for following year, including:
    a) Continued funding for ongoing approved programs/projects; and
    b) Approval of new or revised programs, projects and funding.
4) Response to stakeholder concerns during the public hearing and 30 day posting requirements.

***Accountability***

- Plans must meet basic requirements.
    - Examples: non-supplantation, stakeholder input, majority of PEI funds for those under 25 years, etc.
- Emphasis for accountability will be on consistency of implementation with the plan.
    - Expenditures and clients served will not require contract amendments but should be noted.
- Quality improvement is considered key to moving the system in positive directions.
    - Performance indicators will help assess county efforts for quality improvement (i.e., measuring whether the new admissions into the new system have a greater representation among the underserved communities); these indicators will have a significant role in accountability.

***Integrated Plan***

- Every three years, a robust community stakeholder process will be required to take place within a community quality improvement process to assess:
    - Community needs and priorities;
    - County mental health system strengths and challenges; and
    - Use of MHSA funds as a tool to meet local priorities within the vision of transformation.
- The planning process will be informed by census information, state and regional workforce plans and cultural competence plans.

**Overview of Timelines and Process for Integrated Plan**

***Proposed Timelines***

- Annual Update Guidelines
    - Guidelines complete by September 30, 2008.
    - County submission by February 28, 2009.

- Integrated Plan Guidelines
    - Guidelines complete by July 1, 2009.
    - County submission beginning February 28, 2011.

- Performance Indicators
    - MHSA accountability indicators by September 30, 2008.
    - Overall performance indicators by July 1, 2009.



***Stakeholder Input Process for Annual Update***

- The advisory workgroup, engaging as broad a constituency as possible, will provide expertise and advice to DMH during the development of draft products.
- Materials provided to the advisory workgroup will be posted on the MHSA website.
- Draft products, including summaries, will be distributed widely for input.
- DMH will finalize guidelines.
- In response to concerns expressed in the evaluation of the stakeholder process, DMH recognizes the importance of explaining decisions made that vary from stakeholder input, by articulating rationales in order to close the communication loop with the advisory workgroup.

**Stakeholder Questions and Comments**

***General Standards and Fundamental Concepts—(currently in regulation)***

- **Stakeholder Comment**: Within the General Standards, add “family” to the category of individual; it is not just clients, but families that are recovering.
- **Stakeholder Comment**: In terms of MHSA’s General Standards, the addition of PEI is an important addition.

    - **Response (CH)**: PEI is still in early draft stage.
- **Stakeholder Comment**: Add “outreach to communities” to General Standards. It needs to be highlighted because that is where the disparities are.
- **Stakeholder Comment**: In the General Standards, change “community involvement” to “community engagement”: that term shifts the burden from the communities to the counties.
- **Stakeholder Comment**: In the General Standards, under cultural competence, add linguistic competence. Linguistic competence is very important in California, given that 45% of immigrants speak a language other than English. It is not enough to assume that linguistic competence is included.

***Integration/Budget Concerns***

- **Stakeholder Comment**: The current year’s budget is very frustrating. As a result, it would be better to integrate MHSA with the public mental health money sooner rather than later. Plan to do this for Fiscal Year 2010-11, not 2011-12. This plan is very difficult for the providers and they will not sign off on this timeline.
    - **Response (CH)**: One of the concerns about designing the integrated plans is to have all the components implemented before integration. This will not happen by 2010. DMH believes that it is essential to separate integration itself from the integrated plan. DMH will post guidance for counties concerning integration. This is a particular concern during this challenging budget year, as separation of MHSA from core mental health services that are being cut is a problem. The integrated plan is not the same as integration.
- **Stakeholder Comment**: I thought this meeting was about integrated planning, not an annual plan. Indicators and accountability are essential. Counties are accountable to their local communities. The challenge is that public mental health has an eroding core: the foundations are falling apart while MHSA is putting on a new roof. My goal in coming to this meeting was to work on an integrated plan for our communities.
- **Stakeholder Comment**: It is important that all the guidelines be complete, and that is done. However, all the components do not need to be up and running before counties can do their integrated plans. Improvements and changes that are needed in CSS should be done before the integrated plans. Focusing on the Annual Update is a way to avoid dealing with integrating the components of MHSA. It is projected that there will be a lot of new money for MHSA in 2009-10, so it would be most beneficial to set 2009-10 as the year to simplify and improve CSS. In 2010-11, when the proposed timeline starts, there might not be more money.
- **Stakeholder Comment**: It would be easier to integrate MHSA components as they are being implemented rather than after everything is done. This is true for integration both within the larger system as well as when new components become operational.
- **Stakeholder Comment**: Working simultaneously on all fronts is the best way to achieve integration. An integrated plan sooner rather than later is important. This has been a challenging year with opening and closing services.

***Timelines***

- **Stakeholder Comment**: It is unclear that the counties will agree with the three year phase-in plan. The assumption that smaller counties cannot get themselves ready may also be false. Some smaller counties are nimble and flexible and they are ready now for integration.
- **Stakeholder Question**: The timeline for integrated plan guidelines are a problem that some constituencies will not accept and that might be in conflict with the statute. There are two problems: that it is proposed to take 20 months for the guidelines to be approved and ready for the plans, and that the county plans will be staggered over three years. This sets the bar too low. Why not start with an expectation that counties should integrate their components within a shorter timeframe?
- **Stakeholder Comment**: Simplifying the process is a worthy goal, but the division of splitting counties into three separate groups over time is problematic. It may help DMH's staffing of the review process, but it does not necessarily lead to transformation. It is disruptive to have counties going through their programs, priorities and plans at separate times, especially in terms of training needs. A capacity study is needed to organize the work.
- **Stakeholder Question**: What does DMH plan in terms of integration during 2010-2011?

***Simplification***

- **Stakeholder Comment**: Communities have to implement their programs and DMH needs to eliminate of some of the redundancies and reporting requirements. Then communities can move forward. This has to take place across the spectrum, but we can do some of this right away.
    - **Response (Beverly Abbott (BA))**: DMH has a commitment to simplify and do away with some requirements. But it is important to note that not everyone has implemented all their components. It is important to look at the whole system. It will take time to assess how all the components will work together.
- **Stakeholder Comment**: From a local level, it is good to hear there is awareness of the problems counties are having with MHSA. It is good to hear that DMH has heard the issues, to use the lessons learned into the future.

***Cultural Competence and Underserved Communities***

- **Stakeholder Comment**: DMH has been working on racial and ethnic disparities and will put out a strategic plan about it within the next few months.
- **Stakeholder Comment**: DMH should be commended for reaching out to underserved communities and recognizing that outreach was unsuccessful at the beginning. Excellent work has been done to improve the situation.
    - **Response**: For the PEI component, DMH and OAC went into underserved communities with cultural brokers to hear their voices. Sergio Aguilar-Gaxiola, Ph.D. and the UC Davis Center for Reducing Health Disparities have done an excellent job leading this effort.
- **Stakeholder Comment**: It is important to distinguish between access and quality. One of the big challenges in California is to improve access. Include it as a separate indicator.

***Community Involvement***

- **Stakeholder Comment**: We should celebrate all the foibles, because as of now we have engaged our communities in new ways and offered services, while going through the difficulty of adding and subtracting services at the same time. Because of MHSA, communities have a great base of activated people.

## Performance Indicators – What They Might Be and How They Might Be Used

Joan Meisel, consultant to DMH, gave a presentation on performance indicators. She emphasized that developing and arriving at consensus about performance indicators is not simple. Rather it is complicated and everyone needs to be engaged in the process in order for it to work.

***What the MHSA Statute Says about Performance Indicators***

- Sec 5848 (c): "The department shall establish requirements for the content of the [integrated] plans. The plans shall include reports on the achievement of performance outcomes for services pursuant to Parts 3, 3.6 and 4 funded by the Mental Health Services Fund and established by the department."
- Sec 5848 (d): "Mental health services provided pursuant to Parts 3 and 4 shall be included in the review of program performance by the California Mental Health Planning Council required by Section 5772(c)(2) and in the local mental health board's review and comment on performance outcome data required by Section 5604.2(a)(7)."



***Performance Indicators***

- Performance indicators can be used for
    - Accountability, when someone – usually the funding source – has an expectation or requirement of what will happen. In this case, accountability generally involves achievement of a stated outcome or a consequence of failure.
    - Quality improvement, as a process where someone – usually from within – is working on goals to benefit the system (includes increased access).
- Performance indicators can measure
    - Process: the activities will lead to outcomes, or outcomes themselves, i.e., are people getting better?
    - Person-level (i.e., housing, employment, quality of life), system-level (i.e., number of consumer and family employees, or homeless episodes among clients), or community-level (i.e., suicide rates, which are only partly affected by what the public health system can do) performance.
- A system of performance indicators should indicate
    - What is being measured, by whom and how.
    - What standards of achievement, if any, are expected.
    - What consequences, if any, there are for failure to achieve those standards.

- Lack of clarity about these things creates the challenge of developing performance indicators.

***Basic Proposal***

- Two stages
    - Stage 1: Propose performance indicators, all related to MHSA, that will be measured in the Integrated Annual Update and Budget Request for Fiscal Year 2009-10 and 2010-11.
    - Stage 2: Implement performance indicators for the whole public mental health system to be used by counties in their quality improvement planning process, starting with the Integrated Annual Update and Request for Funds for Fiscal Year 2011-12.
- Each stage has its own process and timeline for development of indicators
    - Stage 1: Indicators would be reviewed by this workgroup for inclusion in plan guidelines completed by September 2008.
    - Stage 2: Indicators to be developed by another workgroup from October 2008 through September 2009.

***Stage 1 Performance Indicators***

- Stage 1 includes basic indicators which reflect that a county has
    - Done what it said it would do with MHSA funds.
    - Abided by the basic MHSA requirements.
    - Begun to share information about the county's performance with stakeholders.
- Performance on Stage 1 indicators will be judged by DMH based largely on the Annual Update submitted by the counties.
- Consequences could be a requirement for explanation and/or plan of corrections.

***Stage 1: Examples of Indicators***

- Does the county do what it said it would do?
    - "The county has begun to implement each CSS workplan or has provided an explanation for why it has not done so."
    - "The county has achieved 85% of its CSS service targets in the majority of its workplans."
- Does the county abide by the MHSA rules and regulations?
    - "The county submits all plans, reports and data in a timely fashion."
    - "The county budgets at least 51% of its CSS funds for Full Service Partnerships (FSP)."
    - "The county certifies that it does not use MHSA funds to supplant other funds."
    - "The county has a plan for achieving the required Prudent Reserve by July 2010."
    - "The county has a separate MHSA account."
- Does the county share performance data with stakeholders in a meaningful way?
    - "The county shares with stakeholders (state provided) FSP data."

- "The county shares with stakeholders trends in the number and Full Time Equivalents (FTEs) of consumers and family members hired with MHSA funds."
- "The county shares with stakeholders (state provided) information from the Revenue and Expenditure Reports."

***Stage 2 Performance Indicators***

- Roles with regard to Stage 2 performance indicators
  - DMH
    - Determines a minimum set of performance indicators which counties must track; allows flexibility on additional ones.
    - Provides data to counties and other stakeholders on most of the performance indicators from existing data sources.
    - Does not set nor enforce standards for the performance indicators.
  - County
    - Conducts the planning process using trends in performance indicators as one measure in its assessment of its system.
    - Shares all data on performance indicators with stakeholders, thus
      - Making the mental health system accountable to local stakeholders; and,
      - Empowering them to better understand and assess their own mental health system's effectiveness.
- Tracking of county trends over time in terms of indicators of
  - Improvement in clinical, functional, and recovery outcomes (for specific persons in FSPs; for clients in the system as a whole).
  - Improved access to the system.
  - Reduction in ethnic disparities.
  - Increased consumer and family driven system.
  - Enhanced wellness/recovery orientation.
  - Reduced negative outcomes from untreated mental illness.
  - Enhanced and improved system of care.
  - These all need to be reported within the county's context. There are a number of possibilities why data might be different from what was expected.

***Stage 2: Examples***

- Is there evidence of improvement in client clinical, functional, and recovery/resilience outcomes?
  - For those receiving FSP services, measure changes over time for specific persons (by age group) in clinical and functional status (e.g., housing, involvement with justice system, institutionalization).
  - For all clients in the system over time:
    - "Trends over time in Mental Health System Improvement Project (MHSIP) and Youth Services Survey (YSS/YSS-F) items: symptoms, housing, school or work, getting along with family, dealing effectively with daily problems."

        - "Trends over time in Quality of Life (QOL) items (e.g., health, safety, social relationships)."
- Is there evidence of improved access?
    - "Trends in penetration rates by age/gender."
    - "Trends in number of clients new to the system"
- Is there evidence of reduced ethnic disparities?
    - "Trends in penetration rates by race/ethnicity."
    - "Trends in race/ethnicity of new clients."
    - "Trends in service patterns by race/ethnicity."
- Is there evidence that the system is more wellness/recovery/resilience oriented?
    - "Trends in relevant MHSIP and YSS/YSS-R items."
    - "Trends in staff perceptions about the programs/services."
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    - "Trends in relevant MHSIP and YSS/YSS-R items."
    - "Trends in staff perceptions about the programs/services."
- Is there evidence that the system is more consumer and family-driven?
    - "Trends in MHSIP and YSS/YSS-F questions on treatment involvement and direction."
    - "Trends in numbers (and FTEs) of consumer and family employees."
    - "Trends in number of consumers and family members employed in management positions."
- Is there evidence that the systems of care have been enhanced and improved?
    - "Trends in involuntary commitments, state hospital and IMD usage."
    - "Trends in availability of community housing options."
    - "Trends in numbers served through integrated or coordinated programs with physical health, forensics, substance abuse."
    - "Trends in numbers of emotional/behavioral health programs in schools and generic community agencies."
- Is there evidence of reduced negative consequences from untreated or inappropriately treated mental illness?
    - "For FSP clients reductions in homelessness, incarceration, school failure, out-of-home placements."
    - "Trends in suicide for all clients."



**Stakeholder Questions and Comments**

***Other Reporting Requirements and Indicators***

- **Stakeholder Comment**: This presentation encapsulates my frustration. Performance indicators for MHSA already exist. The authors of Prop. 63 wanted only functional outcomes. Performance outcomes already exist for the Children's System of Care, which were recently adopted, and the Adult System of Care. The goal of the MHSA was to fully implement AB 2034, and then to use the performance outcomes of the children's and adult systems of care and expand them. Given that these outcomes existed already, the MHSA defined new outcomes only for PEI. It was expected that the existing performance indicators would be implemented. Scrap all of these performance indicators and use the ones in the statute. Otherwise everyone

will be tangled up in red tape. This is the sort of thinking that produced 600 page CSS plans.
    - **Response (BA)**: While this presentation is about indicators, the input for it will be shared with the performance indicators workgroup. Keep in mind that these are only examples of indicators.
- **Stakeholder Question**: Stage 2 applies to the integrated mental health system. How can this be discussed without the other revenue streams?
    - **Response (BA)**: This is a hugely important issue, given the context.
    - **Response (Joan Meisel (JM))**: This is part of the context.
- **Stakeholder Comment**: According to the presentation, in Stage 2, DMH will not set or enforce performance indicators, because it has no authority. However, counties cannot stop reporting on additional indicators, because there are multiple funding streams. It would be extremely challenging to have additional reporting requirements, which should not be enforced or required.
    - **Response (BA)**: DMH does not want to repeat mistakes already made.
- **Stakeholder Comment**: The federal government requires indicators in place. This seems like we are not required to use those indicators.
- **Stakeholder Comment**: There are too many requirements counties are being held to. The real accountability is to the community.
- **Stakeholder Comment**: Some communities have their own indicators of success that might not be shared publicly. Consult with communities for indicators of success.
- **Stakeholder Comment**: Some benchmarks have been established, some have not. The dialogue has to happen with communities.

***Integration***

- **Stakeholder Comment**: The definition of system is primarily the mental health system. It is important to look at how MHSA collaborates with other systems, such as health, aging, justice, substance abuse, etc.
- **Stakeholder Question**: What is the “Integrated Annual Update”?
    - **Response (CH)**: The Annual Update is a document submitted to DMH that describes the activities of all a county’s MHSA components, shows how they fit the MHSA vision and requests MHSA funding for the following year, within approved plans. It is a simplification of what would otherwise be four separate Annual Updates on different components of MHSA. At the same time, an integrated plan involves thinking through how best to integrate all the components of MHSA into a cohesive system within counties. It also involves a broader picture of integrating MHSA into the larger public health system. At the moment, the need to simplify seems the most compelling need in terms of what the counties have to submit to DMH about their MHSA components. The difficulty is that there is an assumption that the MHSA internal system integration and MHSA integration with the broader public health system can not be achieved without DMH requiring an integrated plan. DMH believes that counties have the flexibility to integrate their components of MHSA now. However, the need for indicators that can be measured is the piece that slows down the use of a plan. The indicators are so important to set priorities.

    - **Response (BA)**: If a county has a vision of MHSA, knows the goals, has a robust plan, and wants to look at the components to integrate, there is nothing in the state plan that would prevent them from proceeding with integration.
- **Stakeholder Comment**: Integration can happen before the plan is required.
- **Stakeholder Comment**: Can my county can use the Integrated Annual Plan as the first year in the strategic/three year plan?
    - **Response (CH)**: There is nothing to stop the county from moving ahead with integration.

***Proving Success--Accountability***

- **Stakeholder Comment**: There are a number of indicators that will be important to show the success or challenges of the program. Some examples include how many clients receive how many services, who is providing the services, and whether family members and clients are involved.
- **Stakeholder Question**: Can DMH hold counties accountable for increasing access? Would a consequence of failure be to provide technical assistance?
- **Stakeholder Question**: Should statewide indicators incorporate some goals to be achieved? Stakeholders need to move to a new level of sophistication with risk assessment. This is being done in the health care industry as well as other states in terms of mental health. It is important that when showing the results of counties, that apples are measured against apples.

***Timelines***

- **Stakeholder Question**: An additional problem with the three year implementation timeline is that it disrupts the idea that the whole state moves together. Now the way things operate, as designed, is that in Year 1, counties write their plans; in Year 2, counties report on their progress; and in Year 3, DMH changes requirements for next round. The staggered timeline does not allow the state to move together.
    - **Response (CH)**: There were two reasons for the staggered timeline: 1) in the first round, DMH found that counties were at very different stages, so that it might make sense to group them by stages; and 2) this process will smooth out DMH workload over time. There are clearly other arguments for revisiting this.

## IV. Small Group Discussions

After the presentations, the participants divided into small groups of five to eight people pre-assigned to tables to ensure representation of a diversity of experience and expertise. Each discussion was facilitated by a DMH staff member or consultant, who also recorded the key points of the discussion, using a discussion guide.

The two questions were:

1. What are the strengths of the Integrated Plan approach?
2. What potential barriers to implementation can you identify and what strategies would you recommend toward reducing the potential barriers?

After the small group discussions, each group reported key points back to the whole advisory workgroup. Key discussion points, as captured in writing by the small group facilitators, are described below.

**1. What are the strengths of the Integrated Plan approach?**

***Integration***

- Diminishes the two-tier system, showing an effort to integrate MHSA with the larger public mental health system.
- Will help with budget problem by being able to deal with the system as a whole; if revenue sources are blended, consolidation could enhance leverage and increase the chance of sustaining systemic change.
- Focuses on the whole system.
- Aligned, indicator-driven system is a strength.
- Current synergy with core programs is falling apart. This process could provide greater encouragement and urgency. It is timely.
- Forces DMH and counties to work on the non-MHSA part of the public mental health system to identify and acknowledge problems.
- Takes counties out of silos.
- Enables collaborative governance in community-based service delivery.
- Provides a clearer picture by reporting on all the components together.

***Communication***

- Increases communication with communities about indicators.
- Communicates clearly to stakeholders and the general public, improves communication by allowing the community to understand the whole system, helps counties and DMH to communicate with constituents and funders and brings credibility back to MHSA by helping to communicate about it all in one place.
- Provides a bigger picture of community needs.
- Could serve as a matrix of utilization with a narrative to show how counties are doing.
- Organizes information so that each area of a county system knows what the other areas are doing.
- Provides a better opportunity to engage communities and brings all the issues to one discussion with stakeholders.
- Improves dialogue between DMH and local interested parties, including the Oversight and Accountability Commission, the Mental Health Planning Council, Boards of Supervisors and the California Legislature.

***Simplification and Reduction in Administrative Burden***

- Simplification and streamlining.
- Reduces the number of different plans each county must develop and is therefore more efficient.
- Expedites flow of money to counties as well as state review process.

- Increases continuity of care and simplifies consumer and family member navigation of the system.
- Reduces redundant, multiple processes for stakeholders and requires fewer meetings, thereby preventing stakeholder burnout.
- Reduced administrative burden allows counties to focus on their own administrative work and on implementing the programs. It also reduces administrative burden on DMH.
- Better use and level of service to create efficiencies.

***Transformation***
- It is good to talk about goals: it sets expectations for transformation.
- Shows that stakeholders have reached consensus to move toward transformation.
- Increases the number of clients, family members and other stakeholders as participants at the table.
- Demonstrates willingness to change.
- Helps to entrench transformative values in keeping MHSA separate from the larger context, to keep it from being swallowed up. Ideally, the larger system will be able to use MHSA values across resources, programs and activities.

***Accountability***
- Increases focus on priorities and successes.
- Focuses on accountability and performance rather than compliance.
- Emphasizes prevention and early intervention with measurable outcomes to show success.
- Increases accountability to serve underserved communities.

***Vision, General Concepts and Standards***
- General Concepts are okay; they draw on the Children's and Adults' Systems of Care.
- The goal is fine.

***Workforce Needs***
- Enhances movement in workforce education and training when people know the needs of the whole system.
- The community can see more clearly the workforce education and training needs from this perspective.

**2. What potential barriers to implementation can you identify and what strategies would you recommend toward reducing the potential barriers?**

*Please note that while the small groups were asked to recommend strategies to reduce their identified potential barriers, most barriers were listed without strategies. Where specific strategies were identified, they are listed as an indented bullet below the related barrier.*

***Barriers to Transformation***

- Use of the "same old" language does not show transformation.
    - Adjust language to be understandable to groups.
    - Move outside the office and go into the community.
- Challenge of integrating other systems and providers.
    - Educate other agencies, organizations and other stakeholders as an ongoing process.
- Turf and territory issues among different parts of the public mental health system.
    - Make a compelling argument for why systems need to change.
- Organizational culture differences between the different systems: different ways of serving, different goals, etc.
- The MHSA vision does not permeate through the public mental health system.
    - Highlight short term successes.
- Do not know what transformation means. Good things have happened, but not through the whole system. Staff does not know this.
    - Provide information to staff.
    - Clarify what transformation means.
    - Change methods and staff.
- Lack of awareness of the underserved populations makes it difficult to measure transformation.
    - Do necessary outreach, tap into service providers to report on programs and establish a baseline to show success.
- The report does not show transformation.
    - Engage underserved communities such as youth and cultural communities through various methods.



***Financial Barriers to Integration***

- Challenge of integrating all the other funding streams, i.e., Medi-Cal.
    - Three year planning should include all mental health funding and the whole public mental health system.
- Transitioning the old compliance system (e.g., Medi-Cal) with its own federal requirements to the new integrated system may not be possible.
- Risk of supplantation when integrating MHSA with the larger mental health system, especially when there are cuts in other areas and threats to other revenue streams.
- The non-MHSA client track has essentially disintegrated, which will have an impact on the MHSA client track. How can integration be done within a disintegrating revenue stream?
- Cash flow to counties, loss of staff.
    - Tell counties what funds they will have.

***Barriers to Cultural Competence***

- A simplified Integrated Plan could undermine cultural competence plans and activities.
    - Work with underserved groups while developing indicators.
- Outreach to the underserved population is a problem, including transition-aged youth and older adults.

    - State that MHSA targets people who are not at the table.

***Barriers for Client and Family Members***

- Veterans' needs for themselves and their families will impact MHSA significantly (PTSD, traumatic brain injury, etc.).
- The perception among family members that their family member is worse off than before MHSA.
    - Provide quick results.
- The challenge of maintaining a focus on the family during integration.

***Barriers to Communication***

- Lack of clarity about goal of the Integrated Annual Plan.
- Lack of planning, communication and capability on the local level regarding performance measures and cultural competence.
    - Provide training with local mental health boards on how to use data. Boards need to be aware of cultural competence indicators.
- Forms, document and attachments are too complicated for the public to understand.
    - Develop effective strategies to communicate with the public.
    - Assign a liaison to put materials together and keep them updated and comprehensible.
- Lack of clarity about annual plan, integrated plan and system integration.
    - Be clear about which level is under discussion.
    - Use different kinds of language and explanations to describe how the plans and updates relate to one another (i.e., strategic, tactical, MHSA, whole mental health system).
    - Use different ways to communicate and different methods to get the word out.
- The lack of a qualitative approach may be less engaging.
    - Reports should include narrative with personal stories.
    - Show who is being served.
- Possibly reduced quality of information provided by counties to DMH to the extent that reports will not have narratives that tell a story. DMH will not be able to fully understand what counties are doing.

***Timelines, Risks of Additional Fragmentation and Administrative Barriers***

- The fragmentation of county plans into the proposed three year approval timetable is problematic.
    - Do not require this process.
- Difference between CSS planning and what is happening in the current process.
    - Create consistent planning for multiple components.
- The three year timeline is too long. This is especially true in terms of public perception and patience. Stakeholders want to know whether the program is successful in terms of outcomes to determine whether Californians are getting our money's worth.
- Time and complexity are problems.
    - Plan together: allow counties to use a faster timetable, between July 2008 and January 2009.

- Risk of adding more requirements if integrated report is not sufficiently streamlined.
- Counties still have to turn in each component plan, so delays could increase administrative burden.
- Continued requirements regarding cultural competence and workforce planning are administrative burdens.
- DMH bureaucracy is the problem.
    - Deconstruct DMH bureaucracy.
- Time is a critical factor – how can counties efficiently obtain clarification from DMH on issues that require DMH approval.

***DMH Authority and Information Barriers***

- Lack of consensus about who has the authority within MHSA and other systems as integration moves forward.
- May not have enough state accountability. Need to maintain balance between flexibility and local control on one hand and accountability on the other.
    - Try to establish goals for what constitutes transformation. Identify some process indicators.
- Tension between need for global indicators and appropriate role for DMH in providing oversight.
- Risk of simplifying plans without sufficient accountability.
- Lack of clarification and direction from DMH to counties in terms of definitions.

***Community Organizational Barriers***

- Information technology (IT) systems are currently fragmented, so information sharing with various systems may be hard. This leaves the MHSA story full of holes.
- Some counties do not have technology staff and need to deal with volunteers.
- Counties may not be able to provide a full accounting of all the money available in the community.
    - Require county-by-county accounting or inventory.
- Communities that do not have capacity may not be included.
    - Educate staff to guide local communities.
    - Provide funding for local communities to obtain technical assistance as needed.
    - Provide funding for training.
- Insufficient local engagement to have real local accountability; lack of assurance that counties will include all the stakeholders.
    - Establish guidelines for a basic set of local indicators, e.g., robustness of planning process.
    - Encourage counties to use different ways to communicate and different methods to get the word out.

***Indicator Concerns***

- Variability in counties' readiness and ability to use performance indicators.
    - Train counties and educate the public and community organizations about performance indicators.
- Need indicators.

    - Keep indicators as simple as possible, such as the PEI guidelines.
- Lack of agreement about common performance outcomes.
    - Develop a process to reach consensus about performance and quality indicators that are simple, manageable and meaningful.
- Lack of goals for performance indicators.
    - Set standards and the goals for transformation.
- Impact of PEI on mental health system is unknown.
    - Conduct an impact analysis.
- Lack of clarity about functional performance indicators beyond the children's and adult's systems of care.
    - Build similar indicators: performance indicators should be the same as MHSA process measures.
- Creating the Integrated Annual Update before designing an integration process will mean that indicators will not be in alignment.
- Concern about reinventing the wheel on indicators.
- Do not lose focus on the need for the plans to be informed by best and evidence-based practices.

***External Barriers***

- Methamphetamine addiction.
- The economy: the other systems that have fewer resources to bring to the table want to avail themselves of the MHSA funds.
- Political will is essential, with political leaders openly speaking in support.



## V. Integrated Plan Workplan for July - September

Ms. Hood provided an overview of issues DMH is and will be working on for MHSA. First, she clarified the difference between the integrated plan and the integrated system. The Integrated Plan is one of many strategies to reach an integrated system. She urged people concerned with the timeline to first think about the barriers to integrating the system, and then revisit how the plan or other strategies can help address those barriers..

- **Stakeholder Comment**: The Integrated Annual Update is a report and funding request. The Plan is the plan to reach the goal.

Ms. Hood then spoke about some of the key issues that DMH has been addressing for the MHSA:

- There are concerns about the current context, especially in terms of budget cuts to the rest of the public mental health system.
- DMH will be releasing a number of policy letters to update counties on important MHSA issues.
    - Accountability for counties refers to implementation of the projects that counties described in their plans. Changes in budgets and the number of clients do not require DMH approval. This will eliminate delay and does not

    - There have been many questions about supplantation. The statute says that if a program was in effect on November 4, 2004, MHSA funds may not be used to fund it. DMH considers that if a county closes a program for a particular population, it might open a new program for the same population in a similar but not exact format.
- Counties have been concerned about flexibility for system development. They are encouraged to talk to DMH about these concerns, because system development can refer to the whole county mental health system, not just MHSA programs.
- DMH asked counties to provide a list of concerns and problems. Some of these centered on training issues and other kinds of supports. Ms. Hood encouraged participants to contact her directly if they are aware of other barriers or misunderstandings.
- There will be significant additional funding for Fiscal Year 2008-09.

**Stakeholder Questions and Comments**

- **Stakeholder Question**: When will this advisory workgroup have the opportunity to provide feedback about current situations? Is this something this group will be doing? If each component is going to be added together for the Annual Plan, would it not be advantageous to discuss the components in terms of the requirements, rather than the forms?
    - **Response (CH):** This group was brought together to discuss the Integrated Annual Update. However, DMH will carefully review the feedback and provide a response at the next meeting.
- **Stakeholder Question**: In order to achieve an Integrated Plan, it will be necessary to modify existing CSS requirements to fit into such an integrated plan. We need to make CSS work to fit into an integrated plan, therefore we need to look at the whole system. How do we get to that place?
    - **Response (CH):** We get there by putting all the MHSA components into a single document in which counties state how they will dedicate their priorities. Again, DMH will carefully review the feedback and provide a response at the next meeting.
- **Stakeholder Question**: Can we add “as fast as possible” to the three guidelines of “simplify,” “use indicators” and “integrate”?
- **Stakeholder Question**: The complexities of MHSA are enormous. In order to educate my constituency, a composite document that describes the entire process would be invaluable. Is there such a document?
    - **Response (CH):** DMH will try to put something together. Also, the California Primary Care Association provided an excellent description for its members.
- **Stakeholder Comment**: Several counties put together a PowerPoint about the MHSA to educate stakeholders.
    - **Response (CH)**: Please send it and DMH will post it on the website.

## VI. Next Steps, Feedback on Meeting and Adjourn

Ms. Hood provided an overview of the next steps and process for the next meeting. She made note of the question about reviewing CSS requirements to assess whether changes should be made to CSS to make in order to achieve integration.

The next meeting will be held on July 30. DMH will start that meeting by responding to input from this meeting, such as the staggered three year plan process and the timeframe for integrating the plan and the public mental health system. At the beginning of each meeting, DMH will respond to previous feedback and explain the thinking that went into DMH decisions regarding the Integrated Plan.

Ms. Hood noted that it is important to have as many of the same people present as possible to provide continuity. The topic for the next meeting will be a proposed structure for the Annual Update. DMH will provide an initial draft Table of Contents, which will illustrate DMH's conception of the document. In addition to the discussion about the Annual Update, there will be a discussion about how to measure accountability.



**Summary of Next Steps**

1) DMH will provide a response to today's feedback. The response may be that DMH is still "working on it" but there is a commitment to try to close the communication loop.
2) The advisory workgroup will look at the structure of the Annual Update and consider the amount of information requested. A draft document should be provided two weeks before meeting, or at minimum one week.
3) The advisory workgroup will start the discussion on indicators concerning accountability, considering the basic framework to be: Did the counties do what they said they would do?

**Stakeholder Questions and Comments**

***Funding and Timelines***

- **Stakeholder Comment**: Provide an estimate of upcoming MHSA money.
  - **Response (CH):** DMH does not project funding in that way.
- **Stakeholder Comment**: This information is important to help counties plan.
  - **Response (CH):** DMH will provide an estimate of how much each county will have in 2009-2010.
- **Stakeholder Comment**: Provide a global estimate.
- **Stakeholder Comment**: Stage 2 is probably illegal and unacceptable to some constituencies. The idea that DMH will not implement Phase 2 indicators until years later is unacceptable. The measures are there: use them.
- **Stakeholder Question**: Has anything changed about the timeline in DMH thinking, based on feedback?

- **Response (CH):** There is no timeline yet. DMH is expecting a busy summer. We will have a better sense of what the August meeting will be after seeing the minutes and reviewing the concerns and feedback.
- **Response (BA):** There will be other opportunities to provide input on this issue. It is important to note that some of the issues raised at this meeting are not in the province of this group. But DMH will be sure to determine where to raise them and to let this group know the outcome.

***Other Communication Issues***

- **Stakeholder Comment**: Focus on language: the use of the word "integration" in some many different contexts was confusing.
- **Stakeholder Question**: The issue of prudent reserves is a key issue for counties in terms of how they can spend money effectively. How do reserves work and how is unspent money reported and used?
  - **Response (CH)**: This is a critical issue for counties to truly understand. Anxiety or lack of understanding about how the funding works makes counties more cautious than they might need to be. DMH has held conference calls and provided training to mental health directors on this issue.
- **Stakeholder Question**: The concept of transformation should be revisited. How is the system is going to be changed in three to five years?

***Meeting Clarifications***

- **Stakeholder Question**: Will the meeting on July 30 be the same time, place?
  - **Response (CH)**: DMH will decide and inform participants. There are trade-offs concerning sites: cost of lunch, ease of access to location, comfort and amenities. The next meeting will be a bit longer because there is more work to do: it will begin at 10 am and last until either 3 pm or 4 pm.
- **Stakeholder Comment**: Please add a dollar for coffee and water throughout the day.